Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
VISTA SURGICAL CENTER WEST

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

MFDR Tracking Number
M4-05-A983-01

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
August 2, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "E – Carrier has pre-authorized treatment without proper notice of compensability dispute. The Healthcare Provider is unaware of any TWCC-21 denial filed by the Carrier regarding the above referenced claim. The Carrier has provided prior payment of other dates of serviced for the same diagnosis code."

Amount in Dispute: $706.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier asserts it has properly denied and paid the services in question."

Response Submitted by: Steven M. Tipton, Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2004	Outpatient Surgery	$706.35	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - E – Entitlement (non-compensable)
   - 1 – Unrelated to the compensable injury. (X976)

Findings

1. Has the extent of injury issue been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. Former 28 Texas Administrative Code §133.305(a)(2), effective January 1, 2003, 27 *Texas Register* 12282, defines a medical fee dispute as a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The insurance carrier denied disputed services with payment exception code E – "Entitlement (non-compensable)"; with additional notation "Unrelated to the compensable injury. (X976)" The disputed issue involved whether the compensable injury extends to the diagnosis of brachial neuritis. A Benefit Contested Case Hearing was held on July 19, 2007, to resolve the disputed issue. A decision and order was issued on July 25, 2007 finding that the compensable injury does not include brachial neuritis. The division concludes that the extent of injury issue is resolved.
2. Review of the submitted documentation finds that the provider billed for the disputed services under diagnosis code 723.4 – "BRACHIAL NEURITIS." The services in dispute were rendered for an injury that was not compensable according to the Division's decision and order of July 25, 2007 discussed above. The requestor rendered health care to the injured employee in treatment of the non-compensable brachial neuritis; therefore, reimbursement cannot be recommended for the services in dispute.

Conclusion

The requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	April 17, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.